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Graduate Management Project

Resolving the Nurse Crisis in San Antonio

Capt. James L. Jones

U.S. Army-Baylor Graduate Program in Health Care Administration

1 April, 2007

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Abstract

The purpose of this policy analysis study is to provide options to resolving the nurse crisis in San Antonio. As the metropolitan San Antonio population grows and ages over the next decade, demand for health care services will rise dramatically. The reality is that the supply of nurses is not growing as fast as the demand for nurses is. This growing shortage of nurses threatens the ability of hospitals and other health care providers to continue providing the health care services we all depend on. This report evaluates the nurse shortage, the union, moreover considers the consequences to hospitals of doing nothing, identifies opportunities for collaboration to expand the nurse workforce and recommends strategies that complement efforts already in place.

Disclaimer

The views expressed in this paper are those of the author and do not reflect the official policy or position of the Department of the Army, Department of the Air Force, Department of Defense, or the U.S. Government.

Statement of Ethical Conduct in Research

The nature of the results of this study can be sensitive given the possible solution of unionizing nurses within San Antonio, Texas. Therefore, maintaining the privacy of each nurse is extremely important and no personally identifiable data will be available in this paper.

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Introduction

Background on Nursing:

The profession of nursing has been considered by many to be one of great nobility and respect. Dating as far back to the mid 1800's, Florence Nightengale was the pre-eminent pioneer of nursing and advocated for the sick and injured. Since that era, nursing has evolved into an occupation that incorporates attributes of other professions. Today the nurse profession is a perfect example of multitasking. Nursing involves teaching, counseling, crisis intervention, service attendance, parenting, and mentoring. At present, a typical registered nurse (RN) may perform some or all of the following responsibilities: render direct patient care by cleaning and turning patients, resuscitating patients, assessing vital signs, starting intravenous lines, administering medications, taking verbal telephone orders from physicians, charting and documenting, answering telephones, along with transporting patients to other areas of the hospital. This is why this profession is definitely one of the most stressful careers in today's society.

RN's are the single largest group of health care professionals in the United States (U.S.), strengthening the entire health care delivery system (Buerhaus, Steiger, & Auerbach, 2000). Within large cities, hospitals are the main employers of RN's, licensed practical nurses, and nursing assistants. Unless specifically defined for comparative data, I will only address the nurse occupation as RN's throughout this paper. Moreover, various terms will be utilized throughout this paper and the definitions can be found in the Appendix.

Is There a Nurse Shortage:

A study on this multitasked occupation, published in the Journal of the American Medical Association, estimated that the overall number of RNs per capita would begin to decline in 2007,

and that by 2020 the number of RNs will fall nearly 20 percent below requirements (Aiken et al., 2002). For several decades, RN numbers have continued to increase in relation to the population being served which suggests that the periodic shortages of nurses that the nation has experienced are driven more by increases in demand than by a reduction in quantity. The Bureau of Health Professions under the Health Resources and Services Administration (HRSA), conducted individual state surveys with reference to supply and demand of RN's. After compiling and computing the data, the results revealed that over the next 14 years, the national supply of full time equivalent (FTE) RN's will remain constant between 1.9 million and 2 million (HRSA, 2006). However, according to the Texas Nurses Association, the national demand for FTE RN's will rise sharply to approximately 2.8 million.

Conditions that Prompted the Study:

San Antonio realized the RN supply and demand quandary in 2001 when the Health Professionals Resources Task Force (HPRTF) was created and tasked with "developing and implementing programs to alleviate the nursing faculty shortage so that additional nursing students could be educated at local institutions". Thus, a Nursing Faculty Support and Allied Health/Nursing Scholarship Project was created with the goal of raising funds to support the production of additional RNs. The general goal of the project was to raise interim funding for 25 new nursing faculty positions at area nursing programs during the academic years 2003 - 2005. This provided for training 500 additional RN's over the two-year period and the graduation of 500 new RN's by 2005 (Rasco, W. 2006).

It has been five years since the HPRTF was created. Today, Texas and San Antonio are still experiencing significant nursing shortages along with the threat of unionization of nurses. On

Monday, 17 April, 2006; "Code Red: The Critical Condition of Health in Texas" was released, and within the findings of the report it states (Code Red, 2006):

- There are over 8,000 vacant nursing positions in Texas hospitals.
- By 2010, it is estimated that Texas will have a shortage of more than 52,000 FTE RNs.
- Texas will require an additional 39,000 nurses to achieve the national average in per capita nurses.
- In 2004, approximately 4,200 applicants could not be accommodated in Texas schools of nursing because of inadequate numbers of faculty.

Specifically, the Alamo Region is experiencing a significant RN workforce shortage. This shortage is expected to grow through 2012. According to The Labor Market and Career Information Department (LMCI) of the Texas Workforce Commission, which provides statistics and analyses on the dynamics of the Texas labor market and informational products designed to support informed educational and career decisions, the Alamo Region will have an estimated shortage of 4,100 FTE RNs by 2012 (Labor Market & Career Information Department, 2006).

Furthermore, San Antonio is currently being explored for the possibility of nurse unionization. In the authors opinion, unless steps are taken now to enhance nurse satisfaction and greatly increase the number of RN's and faculty, San Antonio hospitals will fall further and further behind in their ability to care for the community as workforce shortages grow.

Problem Statement:

San Antonio must first consider the issues leading to the actual RN shortage before implementing policy to engage the RN crisis of recruitment and retention. The current RN shortage does have an affect on each of the six aims (safe, efficient, patient centered, timely,

effective, and equitable) for improving the quality of health care systems as promoted by the Institute of Medicine (IOM) and National Quality Forum (NQF). The failure to evaluate what has caused the shortage and the failure to act upon the findings will perpetuate the continuous shortage of RN's within the San Antonio healthcare industry. The continued shortage of RN's will persist to result in appalling patient outcomes due to fatigue making RN's more prone to errors, particularly in critical care areas of hospitals such as intensive care units, coronary care units, and emergency departments.

Evidence

Purpose:

The purpose of this study is to determine possibilities for resolving the RN shortage within San Antonio, Texas. In order for this study to be successful, as the researcher, I must be able to determine contributing factors that have lead to the shortage of RN's. If the shortage of nurses within San Antonio is not corrected, then the lack of nurses will contribute to unforeseen problems that result in injury or death of hospital patients (JCAHO, 2002). Thus the research question is: Can San Antonio Solve the Nurse Shortage crisis in San Antonio?

Nurse Shortage and Impact on Patients:

The U. S. has experienced a cyclic shortage of nurses since World War II. "In 1941 the supply of nurses could not meet the demands of either the civilian or military needs" (Kimball & O'Neil, E., 2002). Research shows that the U.S. does have a shortage of RN's in practice and a shortage of students entering and graduating from nursing programs. In 2002 the Bureau of Health Professions reported that the U.S. was short 125,200 RN's and forecasted that this amount would double by 2010 and exceed 800,000 by 2020. The Bureau of Health Professions began its eighth National Sample Survey of Registered Nurses data collection in March 2004 and

responses were received through November 2005. This report provided preliminary findings from the current survey and showed that of the total national licensed RN population in March 2004; 83.2 percent (an estimated 2,421,458) were employed in nursing, and 16.8 percent (an estimated 488,004) were not employed in nursing. This estimate of the number employed in nursing represents an increase of 219,647 RNs (10 percent) over the projected 2,201,813 RNs employed in nursing in 2000. Also, the report showed that in Texas the total licensed RN population exceeded the national average by 3.1 percent (See Table 1). What's more, Texas has 8.1 percent more RN's employed full time as compared to the National average of 70.1 percent. However, Texas part time RN's are 7.8 percent less than the national average of 29.7 (Bureau of Health Professions, 2004).

Table 1.

Registered Nurse Population in the United States by Activity Status

Geographic Area	Total Number in Sample	*Estimated Total	Total Employed in Nursing	Percent Employed in Nursing	Total Number Not Employed in Nursing	Percent Not Employed in Nursing	*Employed Nurses per 100,000 Population
U.S.	35,636	2,909,467	2,421,458	83.2	488,004	16.8	825
Texas	1,272	168,368	145,336	86.3	23,032	13.7	646

Data was extracted from the preliminary findings of the 2004 National Sample Survey of Registered Nurses

* Estimated numbers may not add to totals and percents to 100 because of weighting and rounding.

** Population data were based on July 1, 2004 estimates of resident population of States from Census Bureau (NST-EST2004-01).

Current hospital RN staffing strategies bring two of the three major cornerstones of the healthcare delivery, access, and quality consequences, for the San Antonio health care system into question. This is due to current shortages which can harm patient's access to care and quality of care if sufficient numbers of experienced RN's are unavailable or if RN workload

increases. According to the Texas Nurses Association; "Hospital cost-cutting measures have contributed to understaffing and poor patient outcomes". Several studies reveal that there is a correlation between the number of RNs in the workforce and patient outcomes. Research has also shown that possibly hundreds to thousands of deaths and injuries each year are attributed to inadequate nurse staffing levels. For example, in 1997, understaffing of RNs was cited as a factor in 402 out of 1,609 unanticipated deaths, injury or permanent disabilities of the ones reported. Inadequate RN staffing levels contributed to 42 percent of surgery-related incidents, 25 percent of transfusion problems, and 19 percent of medication errors (Milan, 2002).

The majority of RNs interviewed reported that the current shortage of RNs is having a negative impact on each of the six goals for improving the quality of health care systems promoted by the IOM, and the NQF. More than 70 percent observed the shortage frequently had a negative affect on timeliness of care, 65 percent felt that the shortage frequently or negatively influenced patient centeredness, effectiveness and efficiency of care, and almost 80 percent felt that the current shortage did have a negative affect on the safety of care. These results almost mirror the findings conducted in 2005 by Buerhaus.

Because of the shortage, health care systems are struggling to ensure that patients receive quality health care despite an insufficient number of RNs. They are taxing the existing workforce to the limit. The retirement of the baby boomers is a perfect example of why this overworked occupation sees turbulent times ahead. The baby boomer generation is expected to contribute to increased demands for health care, as well as decreasing the number of RNs available to provide patient care. Many agree that RNs are the backbone of what hospitals do. And because of the undersupply of RNs, it is not uncommon for thousands of hospitals in the

U.S. to divert and curtail health care services, to include terminating elective surgical procedures (Kimball & O'Neil, E., 2002).

The Agency for Healthcare Research and Quality (AHRQ) conducted a study in conjunction with the National Science Foundation. Between 1991 and 1996, there was a 21 percent increase in patient acuity levels while there was no change in the number of employed RNs. A study conducted by the AHRQ in 1999 surveyed 13,471 RNs in the state of Pennsylvania and 83 percent reported an increase in the number of patients assigned. Almost half of the RNs, 44.8 percent, stated that there had been a decline in the quality of care and only 33.4 percent believe that there are enough RNs (Stanton, 2004).

Even the Joint Commission on Accreditation of Healthcare Optimization (JCAHO) is acknowledging the difference between past and present nursing care delivery issues. JCAHO states that nurse staffing levels need to be evaluated from the perspective of nurse competency, skill mix in relation to patient acuity, and ancillary staff support (JCAHO, 2002).

Texas and San Antonio have similar issues. According to the Code Red Report, today there are over 8,000 vacant RN positions in Texas hospitals, and by 2010, it is estimated that that number will grow to 52,000 (Code Red, 2006). Within the Alamo Region, it is estimated that it will experience an estimated 4,100 FTE RN shortage by 2012 (Labor Market & Career Information Department, 2006).

Aging Work Force

To compound this issue of the nurse shortage, the aging RN workforce has been a major issue for quite some time, and hospitals, by and large, are not taking actions to retain aging workers. According to the preliminary results of the 2004 National Sample Survey of Registered Nurses released in December 2005 by the Federal Division of Nursing, the average age of the RN

population in March 2004 was 46.8 years of age, up from 45.2 in 2000. The RN population under 30 dropped from 9.1 percent of the nursing population in 2000 to 8.1 percent in 2004.

Figure 1 illustrates the dynamic migration of the RN population toward older age groups since 1980. The trend towards an older RN workforce is shown by year groups. In 1980 the prevalent RN population was aged 25 to 29, in 1992 it shifted towards 35 to 39 years of age, in 2000 it shifted towards 40 to 44 years of age, and in 2004 the age group with the largest number of RNs was the 45 to 49 year group. This trend is further demonstrated by observing changes in the percent of RNs in the lower and higher age groups. In 1980, 40.5 percent of RNs were under the age of 35, compared to only 16.6 percent in 2004. On the other hand, the percent of nurses over 54 years of age increased 8.3 percent to 25.5 percent in 2004, compared to 17.2 percent in 1980 (US Department of Health and Human Services, 2006).

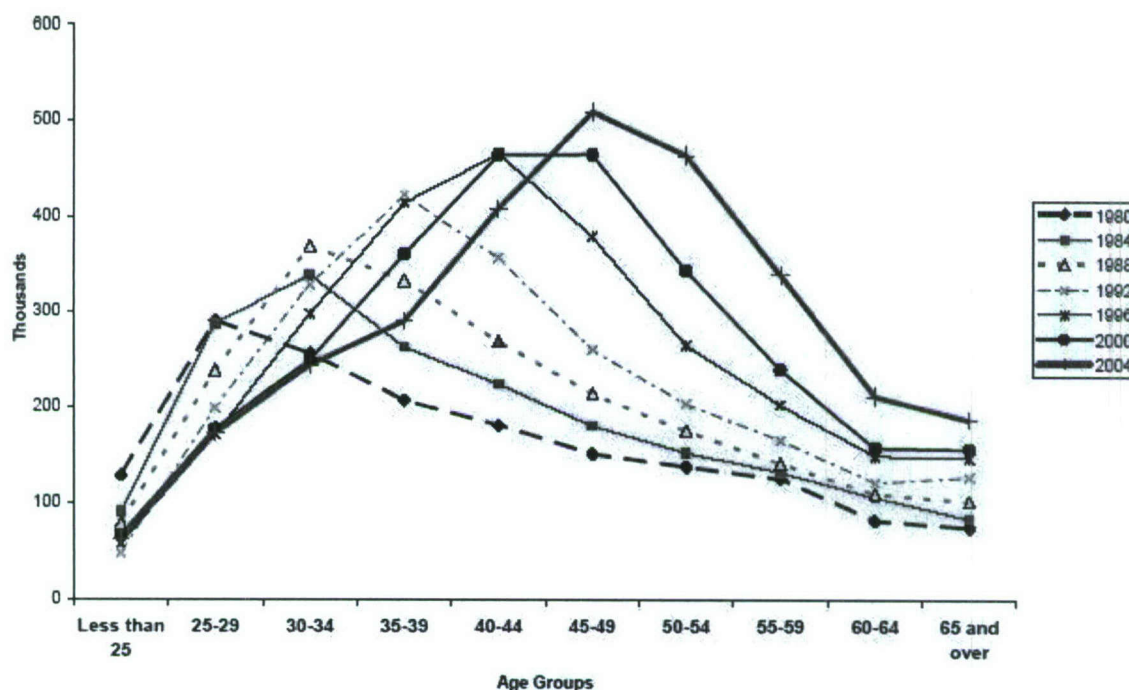


Figure 1. Age Distribution of the Registered Nurse Population 1980 – 2004

Note. Chart was copied with permission from the Department of Health and Human Services “Preliminary Findings: 2004 National Sample Survey of Registered Nurses”.

The RN workforce in Texas is aging at the same rate as the national average. The Texas Nursing Association indicates that the average age of an RN is 46 and that the average age of RN faculty is 53. "The result is the sobering fact that about 57 percent of all RN faculty will reach age 65 and be retirement eligible within the next ten years" (Texas Nursing Association, 2006).

Fewer Potential Nurses:

The aging faculty in conjunction with an inadequate number of facilities for didactic and clinical rotations, budgetary constraints, insufficient clinical preceptors and the shortage of RNs has lead to a reduction in faculty to educate students. Since 1997, there was a 23 percent decline in the number of Bachelor of Science degrees awarded in nursing accompanied by a 9.5 percent reduction in program enrollment (Pomeroy, G. 2002). In 2006, a study of the six San Antonio schools that provide RN equivalent degrees revealed that 50 percent of the institutions had vacant faculty positions which equates to a 16 percent overall faculty shortfall. Also, more than five faculty members were expected to resign in the coming two years. This shortage of faculty imposes significant constraints on student enrollments, impacts contributions to the body of scientific nursing knowledge, and reduces the level of RN participation in strategic leadership roles (Rasco, W. 2006).

Pathway to Nursing Profession:

The nursing profession offers seven nursing education program pathways to prepare for professional nursing practice (Texas Nursing Association. Texas School of Nursing, 2006):

1. **Diploma:** The Diploma programs are hospital-based and include academic courses at nearby colleges or universities. The program lasts two to three years and awards a certificate. Diploma education courses are not equivalent to college credits. San

Antonio has one such program offered at Baptist Health System School of Health Professions (BHSSHP).

2. **Associate Degrees:** The Associate Degree (ADN) or Licensed Practical Nursing (LPN) is typically located in community or junior college setting. The ADN generally takes four regular semesters and one summer session to complete in two to three years. This program prepares a graduate to function as a direct care provider. San Antonio has one such program offered at San Antonio College (SAC).
3. **Baccalaureate Degree:** The Baccalaureate nursing degree, programs generally take four years to complete. A student can either receive a Bachelor of Science (BS) or a Bachelor of Science in Nursing (BSN). BSN is the program that prepares graduates for Master's degree level study, which is a requirement for teaching, administration, clinical specialization and nursing research. San Antonio has two such programs. The University of the Incarnate Word (UIW) and the UT Health Science Center (THSC).
4. **Accelerated Degrees:** There are two variations of this accelerated program:
 - (a) The Accelerated Bachelor's Degree (BSN) Program is for persons with a bachelor's degree in a discipline other than nursing. San Antonio does not have this program available at this time.
 - (b) The Accelerated Master of Science in Nursing (MSN) or Master of Science (MS) Degree is for persons with a bachelor's degree in a discipline other than nursing, "accelerated/fast track" educational programs offer a baccalaureate nursing degree. This usually is usually a three year program. San Antonio does not have this program available at this time.

5. **Fast Track Programs:** There are six variations of this type of program:

- (a) The first Fast-Track Program (FTP) offers a licensed vocational nurse (LVN) an educational path to become a professional registered nurse. San Antonio's Baptist Health System School of Professional Nursing (BHSCPN) has one of the two diploma education programs located in Texas. This program offers transition courses and an accelerated academic track enabling a LVN to gain a diploma certificate and eligibility to sit for the NCLEX-RN licensing examination.
- (b) The second FTP offers a LVN an educational path to become a professional RN. Across the state, more than fifty associate degree nursing program locations offer transition courses and an accelerated academic track enabling a LVN to gain an associate degree and eligibility to sit for the NCLEX-RN licensing examination. San Antonio has two such programs offered at St. Phillips College (SPC) and San Antonio College.
- (c) The third FTP provides an opportunity for a LVN to become a RN with a BS/BSN degree. San Antonio has one such program offered at the UT Health Science Center.
- (d) The fourth FTP gives RNs an opportunity to pursue either a BS/BSN degree. San Antonio has two such programs; the University of the Incarnate Word and the UT Health Science Center.
- (e) The fifth FTP offers RNs an opportunity to pursue a MS/MSN degree. San Antonio has one such program; the UT Health Science Center.
- (f) The sixth FTP offers a BS/BSN an opportunity to pursue a Doctorate degree. San Antonio has one of three programs in the state at the UT Health Science Center.

6. **Masters Degree:** The Masters nursing degree programs reflect the traditional educational route whereby a person with a bachelor's degree pursues a MS/MSN Degree. San Antonio has two such programs; the University of the Incarnate Word and the UT Health Science Center.
7. **Doctorate Degree:** The Doctorate programs offer Master's prepared RNs an opportunity to pursue a doctoral degree (PhD, DSN). San Antonio has one such program offered at the UT Health Science Center.

The six schools of nursing education within San Antonio offer programs within the realm of the seven nursing education programs. As shown in Table 2, students have the option within San Antonio of enrolling and completing a diploma, associate degree, baccalaureate degree, master's degree, and or doctorate degree based on personal and, professional needs and goals. RNs will pursue masters and doctoral degrees in nursing to advance their clinical specialization or enter nursing fields of education, administration or research.

Table 2.

San Antonio Registered Nurse Education Program

	BHSSHP	SAC	UIW	UTHSC	BHSCPN	SPC
Diploma	X					
ADN		X				
BSN			X	X		
AD – a						
AD – b						
FTP – a					X	
FTP – b		X				X
FTP – c				X		

Table 2. (continued)

	BHSSHP	SAC	UIW	UTHSC	BHSCPN	SPC
FTP – d			X	X		
FTP – e				X		
FTP – f				X		
MSN			X	X		
Doctorate				X		

Data was extracted from Texas Nursing Association, Texas School of Nursing

The National Advisory Council on Nursing Education and Practice has recommended that “by 2010 at least two-thirds of the basic nurse workforce ought to hold a baccalaureate or higher degree in nursing”. Currently, only about 43 percent meet that criterion. Furthermore, research shows that approximately 71.6 percent of associate degree graduates and 59.9 percent of diploma graduates go on to obtain a bachelor’s degree (Your Nursing Career, 2006).

Unions and Today’s Healthcare Industry:

The National Labor Relations Act (NLRA), also known as the Wagner Act, passed through Congress and signed into law on July 5, 1935 established the rights of employees to organize and bargain collectively with their employers. The NLRA assured that workers would have a choice on whether to belong to a union or not, and promoted collective bargaining as the major way to insure peaceful industry-labor relations. What's more, the NLRA was enacted for the announced purpose of regulating labor-management relations and promoting labor stability within the private industry. The Act sets forth procedures to be followed throughout the different stages of dealings between unions and employees (Benedict & Pfeiffer, 2006).

The NLRA also created the National Labor Relations Board (NLRB) which is currently headquartered in Washington D.C. The NLRB is an independent Federal agency established to

enforce the NLRA as an independent agency. The NLRB is not part of any other government agency--such as the Department of Labor. The Board is made up of members who serve five-year terms and most day to day activities have been delegated to the boards regional offices located throughout the U.S. These offices are responsible for investigating and prosecuting unfair labor practice charges and for conducting representational elections and related proceedings. In San Antonio, this responsibility falls within NLRB Region 16 which is headquartered in Fort Worth, Texas (Benedict & Pfeiffer, 2006).

In 1974, the NLRA was amended to extend coverage to nonprofit hospitals. This caused the courts to struggle with the issue of what constitutes appropriate bargaining units for health care institutions. Then in 1989, the NLRB enacted a rule that defined bargaining units for acute care facilities (excluding psychiatric hospitals and nursing homes). Under the NLRB's "rule", which was approved by the U.S. Supreme Court, eight different bargaining units are potentially appropriate within acute care facilities, with RN's being one of the eight specifically identified under the NLRB's rule (Benedict & Pfeiffer, 2006).

Notably, the NLRB made a series of controversial decisions when they applied a different standard in determining the supervisory status of charge nurse and head nurse. According to the NLRB, "nurses who provide directions to other employees in the exercise of professional judgment (I.e. in the act that is purely incidental to patient care) are not supervisors". In effect, the NLRB said that nurses with the title "Charge Nurse", or "Head Nurse" could make effective recommendations affecting job and pay status of an employee could be considered supervisors. This approach to determine the status of supervisors among nurses has placed the charge or head nurse in bargaining units with staff nurses. This policy by the NLRB has been rejected by the U.S. Supreme Court *NLRB v. Health Care & Retirement Corp. of America*, 511 U.S. 571

(1994). The findings within the case found that "it is up to Congress to carve out an exception for the health care field, including nurses, should Congress not wish for such nurses to be considered supervisors". The supreme court also found that the NLRB was inconsistent with Sec. 2. [§ 152.] of the NLRA as the court found that the four licensed practical nurses involved in this case were supervisors (Latham & Watkins, 1995).

The six sections of the NLRA that are most significant to the RN occupation are:

1. **Sec. 2. [§ 152.] Definitions:** Supervisors are outside the scope of union organization efforts. They are precluded from being included with any employee bargaining unit, to act as agents for the employer, and are precluded for encouraging or supporting union membership. Most importantly, in view of the fact that supervisors are considered agents of the employer. If the supervisor commits an unfair labor practice, the employer will be held responsible for that wrong.
2. **Sec. 7. [§ 157.] Rights of The Employee:** Employees have the right to self-organization, form, join, or assist labor organizations. They also have the right to bargain collectively through representatives of their own choosing, and preserve the right to refrain from any or all activities. The exception to this right is when the employees right to refrain from activities may be affected by an agreement requiring membership in a labor organization as a condition of employment as authorized in section 8(a)(3) [section 158(a)(3) of Title 29, Chapter 7, Subchapter II, United States Code]".
3. **Sec. 8(a). [§ 158.] Unfair Labor Practices by Employer:** It shall be an unfair labor practice for an employer:

- (a) “to interfere with, restrain or coerce employees in the exercise of the rights guaranteed in section 7” [section 157 of Title 29, Chapter 7, Subchapter II, United States Code].
- (b) to form and dominate what are known as hospital unions. The NLRA, § 2(5), defines “labor organizations” as any organization which exists to deal with employees with regard to grievances’, wages, rates of pay, hours of work or working conditions.
- (c) to refuse to hire, to fire, to discipline, or to otherwise discriminate against employees due to union activity.
- (d) to discharge or otherwise discriminate against an employee because he has or given testimony under this Act.
- (e) to refuse to bargain collectively with “a union”, representatives of employees, subject to the provisions of section 9(a) [section 159(a) of Title 29, Chapter 7, Subchapter II, United States Code].

4. **Sec. 8(c). [§ 158.] Expression of views without threat of reprisal or force or**

promise of benefit: Under the provision “employee free speech”, the expressing of any views, arguments or opinions (written or oral) by an employer is not evidence of unfair labor practices if such expression contains no threat of reprisal or force or promise of benefits.

5. **Sec. 8(d). [§ 158.] Obligation to bargain collectively:** Unions have obtained the right to bargain collectively with an employer. The duty to bargain does not compel the employer (or the union) to agree to a proposal or to make concessions. What is required is good faith bargaining.

6. **Sec. 8(g). [§ 158.] Notification of Intention to Strike or Picket at any Health Care**

Institution: It is unfair labor practice for a union

to engage in any strike, picketing, or other concerted refusal to work at any health care facility no less than ten days prior to any action. The union must notify the health care facility/institution in writing and the Federal Mediation and Conciliation Service of their intention. The only exception is in the case of bargaining for an initial agreement following certification or recognition the notice required.

Why and How RN's Call For Unions:

According to the Service Employees International Union (SEIU), forming a union guarantees RN's to be heard because they can speak with one unified voice. By working together as a group, RN's can address key issues and concerns in hospitals and health care facilities. Rather than leaving all the decisions about staffing, patient care standards, and pay and benefits to hospital administrators, having a union will allow RN's the ability to negotiate over:

- Safe staffing
- Higher pay
- Better benefits
- A voice in hospital policies

Since a negotiated union contract is legally binding, management can't arbitrarily change policies or cut benefits without the approval of RN's.

RN's can form unions once they decide they want to come together to improve their jobs. They have the right to form and join unions, and engage in collective bargaining as outlined in the National Labor Relations Act of 1935, which serves as the legal framework for the labor

relations process. According to Fried, Fottler, and Johnson, there are four key participants in the labor relations process:

1. **Management Officials:** Serve as surrogates for owners and employers of an organization.
2. **Union Officials:** Usually elected by members of an organization.
3. **Government:** Participant through executive, legislative, and judicial branches which are located federal, state, and local levels.
4. **Third-Party (I.e. arbitrators):** A professional that uses legal techniques for the resolution of disputes outside the courts.

The process itself involves three phases that are equally essential: the recognition phase, the negotiation phase, and the administrative phase (Fried, B., Fottler, M., & Johnson, J. 2005).

Within the recognition phase, the union solicits members during off duty time to organize employees and to gain representation. Once the union has at least 30 percent of the employees to sign authorization cards, the union can request voluntary recognition. This type of recognition is rare and more than likely the organization will refuse the voluntary recognition of the union. At this point the petition will go in-front of the NLRB for representation. Once the NLRB verifies the authenticity of the signatures collected by the union, a date for a secret ballot is generally held on the grounds of the workplace and during work hours. If the result of the ballot is in favor of unionizing with at least 50 percent plus one vote, the union assumes the duties of the exclusive bargaining agent for all nurses, including non-members except management.

After the union wins the election, it begins the negotiation phase which is a contract on behalf of the nurses in the bargaining unit. The following four basic points are involved during this phase:

1. **People:** Separate the people from the problem.
2. **Interests:** Focus on interests, not the positions that people hold.
3. **Options:** Generate a variety of alternative possibilities.
4. **Criteria:** Insist that solutions be evaluated using objective standards.

This is where, in theory, RNs, and management can best reach an agreement on issues such as wages, hours, and conditions of employment through negotiating differences which is referred to as collective bargaining. This process is an arduous and time consuming process which requires both sides to listen to each other.

Once an agreement between the union and the employer is reached, the agreement is recorded in writing and executed in good faith. The role of the union is to defend RNs and determine the propriety of the medical facilities actions. Hospitals now bear the burden of proof to prove that whatever action was taken was proper and consistent with progressive discipline. If there is a perceived violation of the labor agreement, a grievance is issued. The grievance process contains four main series of steps:

1. **Presentation of grievance:** Issue is presented to first-line supervisor. If not resolved at this level then issue is elevated.
2. **Department Chief:** At this point the grievance is written out, dated, and signed by the employee and union representative. This makes the grievance an official document and is elevated outside the department. If the grievance is not resolved at this level then it is elevated.
3. **In-House Review:** Grievance is reviewed by top management. If it still remains unresolved at the conclusion of this step, the grievance may go to arbitration.

4. **Arbitration:** This step involves a hearing where the union and the medical facility can present their case. The findings and recommendation of arbitration are enforced by the courts unless the decisions are shown to be unreasonable or unsound. If the decisions are found to be unreasonable or unsound. Management of healthcare facilities with labor unions must be aware of the most severe form of labor disputes, "Strike".

Unions and Nurse Perceptions:

An American Nurses Association (ANA) survey found that "55 percent of nurses, disheartened by their experience in nursing, would not recommend nursing as a career" (JCAHO, 2002). For this reason, nurses' job satisfaction is an important issue because of its impact on the quality of the nursing job. Therefore, nurse satisfaction receives a lot of attention in nursing literature but insight into the sources of nurses' job satisfaction is yet scarce, in particular for sources related to organizational structure (Willem A, Buelens M, & De Jonghe I. 2006).

While a professional environment can, and does, exist among nursing staff in some health care facilities, a variety of forces can rapidly change that dynamic. It is when nurses come face to face with some of those forces, such as changes in administration, changes in organizational priorities, and changes in the workforce, that they learn first-hand the importance of having in place a mechanism-like a contract-that can protect their interests and priorities and that can provide organizational accountability for changes in work and working conditions.

According to Rotkovitch, unionization of nurses can result in a loss of professionalism and the weakening of nursing practice. Rotkovitch, speculates that, "Where nurses have been organized for collective bargaining, it's safe to assume that they must have reached the rock bottom of their endurance," and goes on to ask if it's because of an inability to provide adequate

nursing care due to lack of, or inappropriate mix of, staff (Rotkovitch, 1980). Those within nursing who believe in the value of collective bargaining, and who exercise it as a means to overcome oppressive environments within their institutions, face great opposition from administrators-and more specifically from nurses who believe it is unprofessional (Friss, 1994). Collective bargaining has been a valuable tool for advancing the priorities of individual nurses and of the profession and has more likelihood of achieving success than individual action. Given more consideration and acceptance among those in the profession, it could be even better utilized to accomplish the goals of all nurses and to provide increased visibility and credibility for the profession (McClelland, 1983).

Survey's on Nurse Retention:

Due to the dynamics involved in San Antonio regarding unions, the author was unable to conduct a RN satisfaction or retention survey. As a result, the author researched surveys nationwide on nurse satisfaction and retention as far back as 2002. What's more, One-on-one interviews with RNs from various healthcare institutions were conducted in and around San Antonio. The results show that in the early 2000s, many of the reasons for the nursing shortage are the same as those for today. Nursing appears to keep doing what is asked without demanding an increased workforce.

In 2002, JCAHO printed a document called "Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis". This document indicated that nurses continue to leave the profession for the following nine reasons (JCAHO, 2002):

- Increased workloads and overworked.
- Disruptive behaviors by physicians and lack of respect.
- Low staffing levels and insufficient number of trained staff.

- Mandatory overtime.
- Limited career opportunities.
- Low pay and out-of-date benefits packages.
- Violence in the workplace/negative work environment.
- Managed care.
- Too many housekeeping duties.

In 2003, a study titled “Enabling Technologies to Revitalize the role of Nursing in era of Patient Safety” was conducted to look at what challenges revolve around issues of job satisfaction and attracting, and retention of RN staffing in the midst of a serious RN shortage. This study revealed that pay was not necessarily the main reason RNs stay at hospitals although there are four main reasons that could attract and impact retention of RNs (Ball, Weaver, & Abbott, 2003):

- Eliminate mandatory overtime.
- Improve nurse-to-patient ratio.
- Provide a voice for nurses in hospital policy.
- Improve nursing informatics (electronic work environment).

In 2004 the Regional Center for Health Workforce Studies of The University of Texas Health Science Center San Antonio Texas in partnership with the Texas Nursing Association conducted a third assessment study on Texas RNs titled “Health and Nurses in Texas: In their own words”. This study centered on career plans and perceptions of professional fulfillment. This study identified that while RN commitment to employers is high, RNs are demanding more assistance from employers in managing workload effectively, minimizing perceived harassment from families and physicians, improving patient-care support and providing training on new

technologies (Reineck, Furino, Lucke, Martinez, & Wood, 2004). The study pointed out the following six categories that have an effect on RN satisfaction and retention:

- Ergonomics
- Paperwork
- Severity of patient illness
- Increase number of patients assigned
- Increase in RN turnover
- Violence and harassment by patients

In 2005, a survey titled "Hospital RNs' and CNOs' Perception of the Impact of the Nursing Shortage on the Quality of Care" was conducted to look at what impact the RN shortage in hospitals has had on the six aims for improving quality care. This study revealed that more than 80 percent observed that the shortage had frequently or often negatively affected the timeliness of care, over 70 percent perceived that the shortage had frequently or often negatively influenced patient centeredness, effectiveness and efficiency of care; and almost two-thirds of RNs' reported that the shortage had negatively affected the safety and equity of care (Buerhaue et al., 2005). The survey results provided five implications for policy makers, employers, and nurses interested in strengthening the current nursing workforce and averting the projected long term shortage of RNs

- Fix problem associated with a negative workplace climate.
- Measure and improve the contributions of nursing in patient quality and safety initiatives.
- Promote a balanced and professional image of nurses.
- Improve diversity in the workplace.

- Recognize that positive changes in the workforce are possible.

In 2006 the Robert Wood Johnson Foundation conducted a study titled "Wisdom at Work". This study surveyed 377 nurses to determine what it would take to make the workplace more attractive (Hatcher et al., 2006). This document made five recommendations:

- Revised employment policies, such as greater flexibility in scheduling and innovative new nursing positions.
- Better ergonomics and healthcare design, to reduce the walking on the job and reduce physical strain of some duties.
- Improved introduction and use of technology, such as offering adequate training and seeking older nurse input into decision making.
- Changes in organizational culture.
- Commitment to training and education.

A one-on-one interview with 63 RNs representing five San Antonio medical institutions was accomplished August 2006 through January 2007. Although the one-on-one interviews do not reflect the total RN population in terms of demographics, it serves as a "benchmark" in understanding what hospitals within San Antonio should do to improve the work environment and quality of care. The following are what RNs consider the top ten things that hospitals need to correct and/or improve the RN work environment and improve the quality of care patients receive:

- Insufficient time available for direct patient care.
- Unrealistic staffing patterns and duty schedules.
- Inadequate information system technologies.
- Improve nurse-to-patient ratio.

- Lack of participation in governance, management, and administration.
- Lack of collegial communication and collaboration.
- Underutilization of professional skills.
- Lack of clinical decision-making authority and autonomy.
- Lack of incentive programs commensurate with civilian market.
- Poor compensation.

Choices are made in hospitals every day that effect nursing, but the question we musk ask is how often is nursing represented during those choices? The RN's scope of care allows clinical duties of support staff to easily be placed on the RN. For example, if respiratory therapy is short; nurses can give their own nebulizer treatments, if Lab is short; nurses can do all of their own lab work, if Dietary is short; nurses can come and get all late trays. The list goes on. According to the American Nurses Association, "Nurses leave hospitals because they are overworked and overburdened, often with tasks that were once the responsibilities of less skilled workers". Of the 63 RNs interviewed, 48 (75 percent) reported having to perform non-nursing tasks. As stated earlier, nurses in general have a disgruntled opinion with the profession related to staffing shortages and a sense of burn out.

Best Practices:

According to the American Hospital Association and the American Nurses Association financial incentives are extremely successful in recruiting and retaining nurses. According to Steven O'Connor, in 1999 more than 40 percent of the hospitals surveyed offer recruitment bonuses as high as \$15,000 (O'Connor, S., 1998). Mary Foley, presiding American Nurses Association Vice-Chair, Political Action Committee, Washington D.C., believes scholarship and grants are important for increasing enrollment of nursing faculty and students.

In an effort to assist nursing schools financially, some hospitals have directly subsidized RN faculty salaries by loaning their own RNs to serve as nursing faculty. This is accomplished by paying the RN faculty with a full clinical level salary. Hospitals have also gone the extra step by assisting nursing schools to locate faculty (May, J., Bazzoli, G., & Gerland, A., 2006).

Various hospitals in Cincinnati provided \$30,000 RN retention bonuses in return for a two-year work commitment. In Nevada staff members can get up to a \$2,000 finder's fee for every nurse they recruit who stays with the organization for six months to a year. Health care organizations in Florida offer a \$7,500 down payment on a new home. Lucrative sign-on bonuses are the recruiting tool of choice. Student loan forgiveness is another tactic gaining momentum (Lamb, 2002). These extra incentives assist nurse recruiters in finding candidates. The addition of a hefty retention bonus is valuable for preventing competitors from luring away quality employees. Some of these incentives are controversial: critics claim that these enticements are a temporary solution; that the only thing that they do is redistribute, not increase the supply of nurses. Such observations have merit. Nonetheless, these incentives are very popular. American hospitals are resurrecting aggressive recruiting efforts of nurses overseas (Hansen, B., 2002).

One professional organization which has formed a coalition with industry to enhance the image of the nursing profession and to recruit nurses is Johnson and Johnson (J&J). J&J launched an aggressive \$20 million dollar marketing, advertising, and recruiting campaign from 2002 through 2004. The campaign sought to bring nationwide attention to the shortage of nurses, to enhance the image of the profession, and to recruit more males and minorities in nursing. Today if one goes to the J&J website, he or she will find a link specifically addressing J&J's campaign for the future of nursing. Within this campaign a person can find items ranging

from scholarships to careers in nursing.

Some other initiatives to attract people to the nursing profession are designed to improve technology and reengineer professional staffing models to reduce dissatisfaction in the work. San Antonio RN's interviewed expressed concern that the health care industry still fails to improve the work environment of health care professionals. The health care industry has ignored the technological needs of an overburdened, frustrated, stressed, and diminishing staff. Archaic technology has increased the amount of time RNs spend away from patients because technology has hindered efficient and effective means to reduce paperwork and redundancy. San Antonio hospitals are currently upgrading technology for staff use to increase efficiency and safety.

The Joint Commission on Accreditation of Healthcare Organizations, Health Care Facilities and Nursing Associations are re-engineering professional staffing models. Research shows that nurses are attracted to and stay longer at "Magnet" hospitals than at other facilities. These organizations cultivate nurse autonomy and foster transformation of nursing work through the use of mentoring roles and ergonomic technologies. Further, magnet hospitals set staffing levels on the basis of nurse competency and skill mix relative to patient mix and acuity. San Antonio currently has hospitals striving for "Magnet" status.

Policy Options

Presently the city of San Antonio is unable to meet the local demand for RNs, and has four options to consider. By implementing one or more of the four options, San Antonio can expect one or more of the following results: decreased RN vacancies, increased quality of care, increased continuity of care, increased patient satisfaction, and increase qualified RNs within the community. The following are the four policy options that may be considered to resolve the RN shortage:

1. **Status Quo:** Maintain current practices both within the healthcare and educational industry.
2. **Change Current Legislation to Increase RN Faculty Wages:** Current the average salary for nursing faculty within San Antonio remain particularly low compared to wages earned by practicing RNs. Salaries need to be increased to attract and retain the faculty needed to teach. The result will increase enrollment which will provide more RNs into the industry.
3. **Human Resource:** The healthcare facilities within San Antonio will need to focus on the needs of RNs to increase retention and recruitment.
4. **Unionize:** Allowing the union to organize will guarantee RN's to be heard because they can speak with one unified voice. By working together as a group, RN's will be able to address key issues and concerns in hospitals and health care facilities.

There is one main assumption that must be considered when using the four policy options. The assumption is that there will be no decrease in the estimated \$60,000 annual salary for faculty.

Evaluation Criteria

Theoretical Overview:

A review of the literature suggests that a research model of causes and consequences of nursing shortage and unions does not exist. Therefore, the author had to create one, as shown in Figure 2.

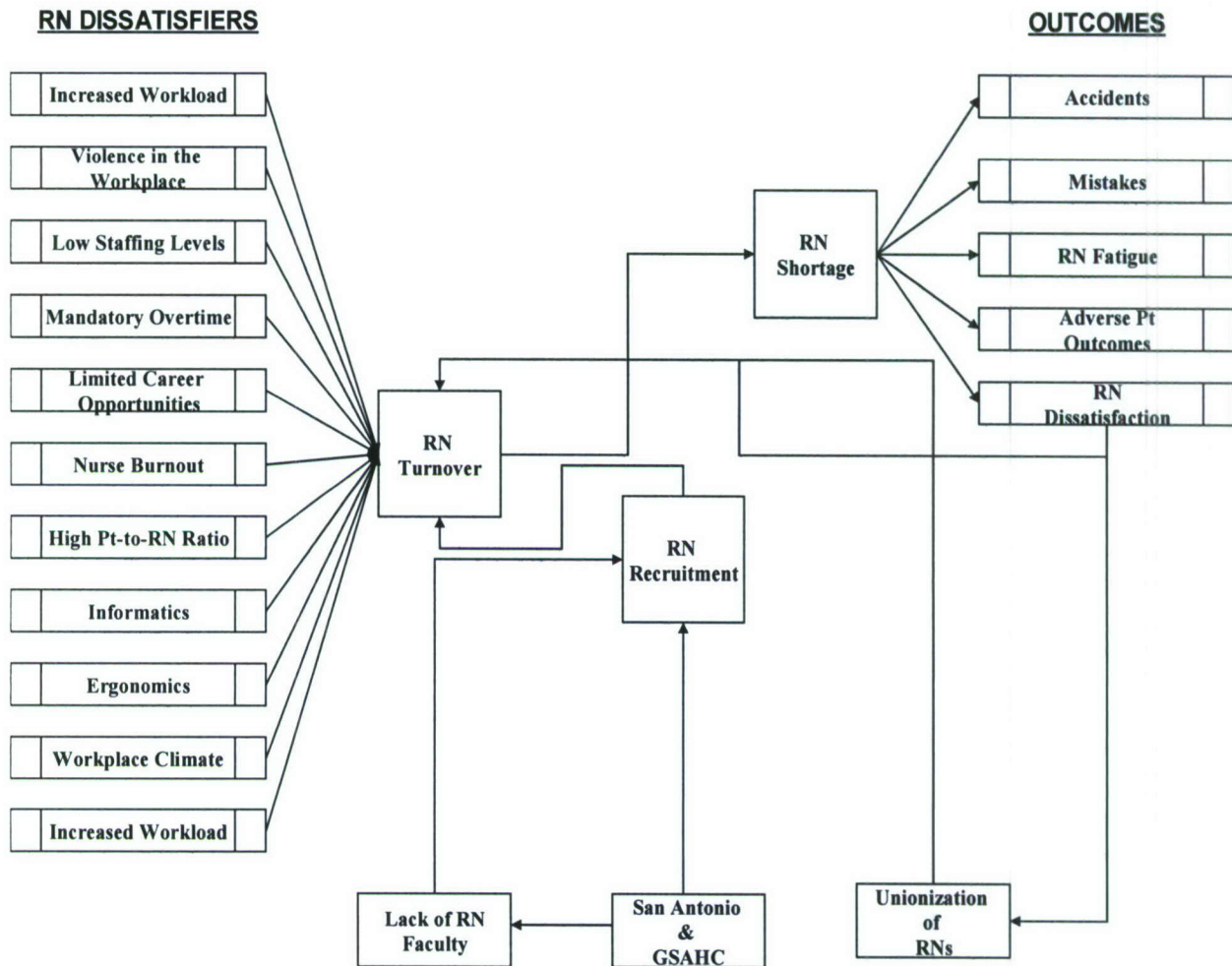


Figure 2. Conceptual Nurse Shortage Cause and Consequences Model

The following eleven independent variables (IV) are the RN Dissatisfiers that lead to RN turnover which in turn contributes to the RN shortage.

1. **Increased Workload:** caused by RN shortage, which leads to unwanted overtime, which leads to RN turnover (JCAHO, 200).
2. **Violence in the Workplace:** caused by disruptive behaviors by physicians and patients, this leads to a negative work environment, which leads to RN turnover (JCAHO, 2002).

3. **Low Staffing Levels:** caused by unrealistic staffing patterns and duty schedules, this leads to RN turnover (One-On-One Interviews, 2006).
4. **Mandatory Overtime:** caused by insufficient staff, which leads to unsatisfied staff, this leads to RN turnover (Ball, Weaver, & Abbott, 2003).
5. **Limited Career Opportunities:** caused by limited growth potential within the industry, which leads RNs to pursue careers outside the patient care setting, which leads to RN turnover (One-On-One Interviews, 2006).
6. **Nurse Burnout:** caused by increase severity of patients, and a lack of collegial communication and collaboration, this leads to RN turnover (Reineck, Furino, Lucke, Martinez, & Wood, 2004).
7. **High Patient to Nurse Ratio:** caused by increase severity of patients, this leads to RN turnover (Ball, Weaver & Abbott, 2003).
8. **Informatics:** caused by lack of technology, this leads to RN turnover (Ball, Weaver & Abbott, 2003).
9. **Ergonomics:** caused by undue physical strain on the body, which leads to on the job injuries, this leads to RN turnover (Hatcher et al., 2006).
10. **Workplace Climate:** caused by changes in organizational culture, this leads to RN turnover (Hatcher et al., 2006).
11. **Increased workload:** caused by to many housekeeping duties, lack of technology, increased severity of patient, lack of participation in governance, management and administration, which leads to RN turnover.

Once a healthcare network like San Antonio has a shortage of RN's, one or more of the five following outcomes may occur:

1. **Accidents:**
2. **Mistakes:**
3. **Nurse Fatigue:**
4. **Adverse Patient Outcome:**
5. **Nurse Dissatisfaction:**

According to the SCIU, unionization of RN's has been shown to improve working conditions that can impact seven of the eleven IVs that cause RN turnover which decreases the market RN shortage: 2 (violence in the workplace), 4 (mandatory overtime), 5 (limited career opportunities), 7 (high patient-to-nurse ratio), 8 (informatics), 9 (ergonomics), and 10 (workplace climate).

However, simply putting a union in place that addresses reasons that cause RN turnover does not solve the actual supply shortage of RNs. The Greater San Antonio Hospital Council (GSAHC) of San Antonio has been addressing the issue of supply regarding RNs since 2001, and has had an impact on RN recruitment (Rasco, 2006). By addressing the shortage of faculty, the issue of recruitment is addressed and has a direct impact on five of the eleven IVs: 1 (increased workload), 3 (low staffing levels), 4 (mandatory overtime), 6 (nurse burnout), and 11 (increased workload). Correcting issues that cause RN turnover will improve the market RN shortage.

Pros to Unionization:

Forming a union guarantees RN's are heard because they speak with one unified voice. By working together as a group, rather than as isolated individuals, RN's can address key issues and concerns in hospitals and health care facilities. Creating a union also gives RN's a voice in a wider arena where decisions that affect jobs and patients are made. Together, RN's can effectively challenge the political influence of large corporate interests and insurance companies. With organized representation, RN's are able to lobby and mobilize community support around

legislative and regulatory measures that promote quality patient care (Why Nurses Form Unions, 2006). The following is a list that was retrieved from the Human Resources in Healthcare, Second Edition (Fried, B., Fottler, M., & Johnson, J., 2005), and one-on-one interviews with RN's in San Antonio which are perceived items of interest that forming a union will solve:

- Increased Pay: More often than not, unions initially get a substantial pay increase through their collective bargaining efforts.
- Job security: Unions have had a successful history of keeping union members employed (Fried, B., Fottler, M., & Johnson, J., 2005).
- Representation During Disputes: RNs have a voice and hospitals are forced too actually listen to their needs (Fried, B., Fottler, M., & Johnson, J., 2005).

Consequences to Unionization:

On the other hand it has been postulated that unionization of RN's can result in a loss of professionalism and the weakening of nursing practice. Rotkovitch speculates that, "Where nurses have been organized for collective bargaining, it's safe to assume that they must have reached the rock bottom of their endurance". He goes on to ask if it's because of an inability to provide adequate nursing care due to lack of, or inappropriate mix of, staff (Rotkovitch, 1980).

The following is a list that has been highlighted throughout the literature and one on one conversations with RN's in San Antonio about what unions would either hinder or not solve:

- Increased Pay: One interviewee, who recently moved from a unionized hospital, noted the more often than not, unions initially receives a substantial pay increase through their collective bargaining efforts. However, unions also tax employees with union dues. Consequently the RNs take home pay may not be increased as much as one would think.

- Patient Outcomes: Although research shows substantial relationships between several organizational characteristics in hospitals and patient outcomes, the relationship between nurse unions and patient outcomes has not yet been fully explored. Because of the workplace chaos of the last half of the 1990s, some nurses are rethinking their relationships with unions. It is not always clear whether changes in health care are associated with patient outcomes, but it is clear that hospitals/health systems with unions often engage in spirited rhetoric about what is best for patients with little objective evidence to support either view (Seago, J., & Ash, M., 2002).

Projected Outcomes

The city of San Antonio started to combat the RN shortage in 2001. In the first option “Status Quo”: San Antonio maintains current practices both within the healthcare and educational industry. Through maintaining current practices within the education industry, the increase in qualified RNs into the industry will increase as shown in Figure 3.

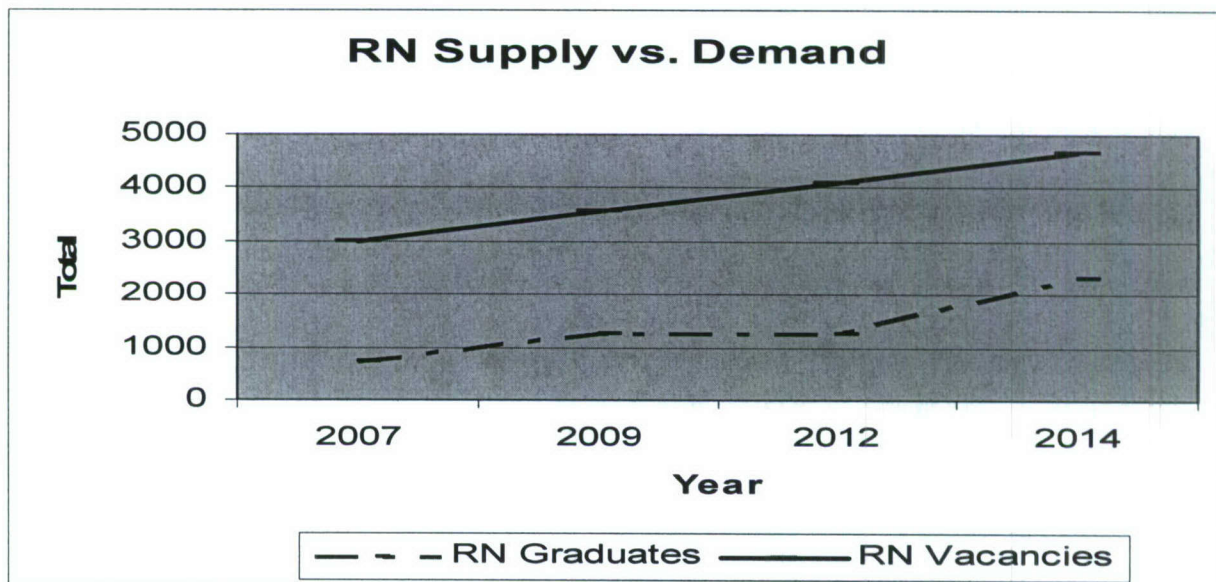


Figure 3. San Antonio Texas, Registered Nurse Supply and Demand Over Time

Figure 3 shows projected RN FTE shortages and RN graduates into the Alamo region. According to the Labor Market and Career Information (LMCI) Department states that the Alamo Region is projected to see a 273 RN FTE increase in demand per year. The LMCI projects that in 2007 there will be about 3,000 RN FTE shortages and ending in 2014 the RN FTE shortage is projected to be 4,646. The figure also shows the combined San Antonio six schools of nursing are preparing to graduate 704 RN's on 2007. With the estimated retention rate and probability of student and faculty capacity. The six San Antonio schools of nursing are estimated to graduate 1,260 RN's by 2009 and 2,320 RNs by 2013. The RN supply vs. demand scenario is constant. In 2007, by taking demand (projected RN FTE shortage) and subtracting supply, (projected RN graduates from the six schools of nursing) you get a projected RN shortfall of 2,303 RNs. In 2014, by using the same demand vs. supply scenario, you get a projected RN shortfall of 2,326 RNs. This demonstrates that maintaining current practices within the education industry the city of San Antonio, at best, is keeping the current RN FTE shortfall for the next seven years even at 2,300.

In the second option "Change Current Legislation to Increase RN Faculty Wages": Some economists have described the RN shortage as an overarching imbalance of supply and demand attributed to demographics, qualifications, availability and willingness to do the work. Thus, the law of economics has taken hold of the RN occupation in Texas and San Antonio. Texas Legislature should invest the funds necessary to increase faculty wages in order to supply more RNs into the communities. According to the Texas Higher Education Coordinating Board; it has recommended that at least \$50 million be appropriated for nursing education. This \$50 million would be used in the following four ways:

- Fund the additional faculty positions needed to increase enrollments.

- Increase faculty salaries to make teaching competitive with clinical nursing positions readily available to masters-and doctoral-prepared nurses.
- Provide financial aid and other incentives to recruit and retain qualified faculty.
- Provide incentives for nursing schools to graduate more of their students on time.

The essence of a dynamic RN shortage is that the basic considerations, such as, supply of RNs and the demand for their services change overtime in such a way that the shortage will continue for years. Currently, according to the Code Red Report, Texas and San Antonio are experiencing a decrease in supply and an increase in demand which equates to a crisis. The approval of the Texas Higher Education Coordinating Board proposal of \$50 million to be appropriated for nursing education will increase the overall supply of RNs. This is an issue that Unions do not address.

The third option "Human Resource": It is essential that San Antonio hospitals focus on what the needs of the RNs are which will have a positive impact on the six aims (safe, effective, patient centered, timely, effective, and equitable) for improving the quality of health care systems promoted by the IOM and the NQF. This author suggests that this can be accomplished through the utilization of a department specific checklist that addresses seven of the key issues addressed in Figure 2 "Conceptual Nurse Shortage Cause and Consequences Model": 2 (violence in the workplace), 4 (mandatory overtime), 5 (limited career opportunities), 7 (high patient-to-nurse ratio), 8 (informatics), 9 (ergonomics), and 10 (workplace climate). By utilizing the checklist, as shown in Table 3, RNs will have their own internal voice to ensure hospitals will address their needs. This may bring about RNs not seeking unionization for assistance in addressing their needs.

Table 3.

Checklist

HOSPITAL _____	DATE _____
DEPARTMENT/UNIT(S) _____	
INSPECTOR(S) _____	

RN Recruitment/Retention

[illegible]

With the needs of the RNs addressed, retention rates and quality of patient care will increase. This option, based on feedback from RNs interviewed locally, will improve the current RN retention and recruitment rates. However, this option also does not resolve the actual issue of the supply of RNs into the industry.

Lastly "Unionization": Unions will guarantee RN's are heard because they speak with one unified voice. Like option three "Human Resources", RN's can address seven of the key issues addressed in Figure 2 "Conceptual Nurse Shortage Cause and Consequences Model": 2 (violence in the workplace), 4 (mandatory overtime), 5 (limited career opportunities), 7 (high patient-to-nurse ratio), 8 (informatics), 9 (ergonomics), and 10 (workplace climate). What's more, like option three, "Human Resources", unionization of RNs will have a positive effect on each of the six aims (safe, effective, patient centered, timely, effective, and equitable) for improving the quality of health care systems promoted by the IOM and the NQF. Like option three, this does not resolve the actual issue of the supply of RNs into the industry.

Recommendations

San Antonio needs to continue with its current policy and look long term at the education of new RNs and the recruitment and retention of nurses in the workplace. As shown in Figure 3, using supply and demand, it is imperative that the RN education industry in San Antonio continue to combat the shortage of supply through increasing the rate of new qualified RNs entering into the healthcare workforce. This author suggests that this can only be accomplished by changing current legislation policy and simultaneously raising the salary of RN educators. At the same time, the hospital industry within San Antonio needs to expand its current HR policy to include the need to listen to what the RN community is saying and wanting. While unionization of RNs will provide an active voice and force the hospital setting to listen to the needs of the RN. The hospital industry can utilize a variation of the checklist as outlined in Table 3 which provides an active voice for the RNs, and subsequently the RN community will not need the union to act as a voice on their behalf.

It was very difficult to obtain real historical data regarding supply and demand because contacted organizations, such as the Texas Board of Nursing Examiners, for example only hold data for one or two years. The Texas Board of Nursing Examiners should establish a policy to archive data collected for future short term and long term studies. Also, the author was unable to locate articles or data that would show RN supply vs. demand for Texas, the Alamo Region or San Antonio. Lastly, future research should be focused on the impact of unions on the health professions. This author was unable to find literature for or against unions in regards to RN staffing. For further studies, it is suggested to try to validate whether or not hospitals that have unions have seen a true increase in RNs within the institution, an overall improvement in surgery related incidents or an overall decrease in transfusion problems or medication errors.

Conclusion

Although San Antonio hospitals are using strategies aimed at making longer term staffing improvements, concerns about the future supply of RN's is apparent and the Unionization of RN's will not solve the RN shortage within San Antonio, Texas. The union and the implementation of a checklist are options that RNs can utilize to address working conditions. However, neither the union nor a checklist will resolve the RN shortage problem in San Antonio because neither one addresses the root problem of the shortage which is the lack of nursing faculty to educate and grow future RNs.

The Greater San Antonio Hospital Council had a vision six years ago and knew that efforts were insufficient to meet future RN demand. This concern continues and is exacerbated today via hospital capacity expansions under way, which will require additional nursing staff. A change in the current policy in San Antonio regarding RN education, and/or a change in current legislation to increase RN faculty wages does take the appropriate steps in addressing the root problem that is causing the RN shortage in San Antonio, Texas, and the U.S.

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Appendix

Terms Defined

Registered Nurse (RN)	A person currently registered by the Texas Board of Nurse Examiners to practice professional nursing.
Licensed Practical Nurse (LPN)	A person who is specifically prepared in the techniques of nursing, who is a graduate of an accredited school of practical nursing and whose qualifications have been examined by the Texas State Board of Nursing, and who has been legally authorized to practice as a licensed practical nurse.
Nursing Assistant (NA):	A person under close supervision performs a variety of non-professional tasks is providing direct bedside care to patients; and does related work as required.
Full Time Equivalent (FTE):	A measurement equal to one staff person working a full-time work schedule for one year.
Intensive Care Units (ICU's)	A specialized section of a hospital containing the equipment, medical and nursing staff, and monitoring devices necessary to provide intensive care.
Emergency Departments (ED's)	A specialized section of a hospital containing the equipment, medical and nursing staff, and monitoring devices necessary to provide intensive care.
High Pt-to-Nurse Ratio	Five nurses to one patient
Mandatory Overtime	Have to work 60 hours in a week to meet patient demand due to lack of nursing staff.
Nurse Burnout	A psychological term for the experience of long-term exhaustion and diminished interest of job
Nurse Fatigue	Tiring effort or activity, that causes weariness
Adverse Pt Outcomes	Adverse condition not present on admission
Quant III	Quantitative Analysis III: Decision Making with Statistics and Research
Army-Baylor	Army-Baylor Graduate Program in Health and Business Administration, Fort Sam Houston, Texas 78234
Fellow American College Health Executive (FACHE)	The FACHE credential is a testimony to achievement of the highest standards of professional development. It demonstrates commitment to a career in healthcare administration, organization and to the patients and families that an individual is privileged to serve

Acute Care	Medical care administered, frequently in a hospital or by nursing professionals, for the treatment of a serious injury or illness or during recovery from surgery. Medical conditions requiring acute care are typically periodic or temporary in nature, rather than chronic
Charge Nurse	The Charge nurse functions as a permanent shift charge nurse for a unit or ward and provides direct patient care to patients having physical and/or mental disorders.
Head Nurse	Head nurses and supervisors supervise and co-ordinate the activities of registered nurses, licensed practical nurses and other nursing personnel in the provision of patient care. They are employed in health care institutions such as hospitals, clinics and nursing homes and in nursing agencies.
